The Interim Newsletter

A Monthly Publication
November 2016

In This Issue

Save the Dates! Caucus and Orientation for Session

The 2016 dates related to preparation for the 2017 legislative session are as follows:

- Caucuses — Monday, Nov. 14 (morning).
- Training and orientation — Monday, Nov. 14 (afternoon) through Wednesday, Nov. 16.
- Legislative dinner — Monday, Nov. 14, 6 p.m.
- Rules committees — Wednesday, Dec. 7 (morning).
- Presiding officer training — Wednesday, Dec. 7 (afternoon).
- Budget training, 2019 Biennium Budget review, and other topics — Thursday, Dec. 8.
- Look for a potential training on civil discourse in early December!

The first day of the 2017 session is Monday, Jan. 2, 2017. The House and the Senate will each convene at noon.

The tentative session calendar may be found online at the 2017 session web page.

The Capitol Shuttle Is Back!

The City of Helena Capital Transit, the Department of Administration, and the Legislative Services Division have again joined forces to provide you with the Capitol Shuttle for the 2017 legislative session. The shuttle will operate from 6:30 a.m. to 6:15 p.m. starting the first day of the session and will run between the Capitol Hill Mall east parking lot to the south entrance of the Capitol building.

For more information, please contact Sheila Hogan at the Department of Administration, shogan@mt.gov or 406-444-2032, or Susan Fox at the Legislative Service Division, sfox@mt.gov or 406-444-3064.

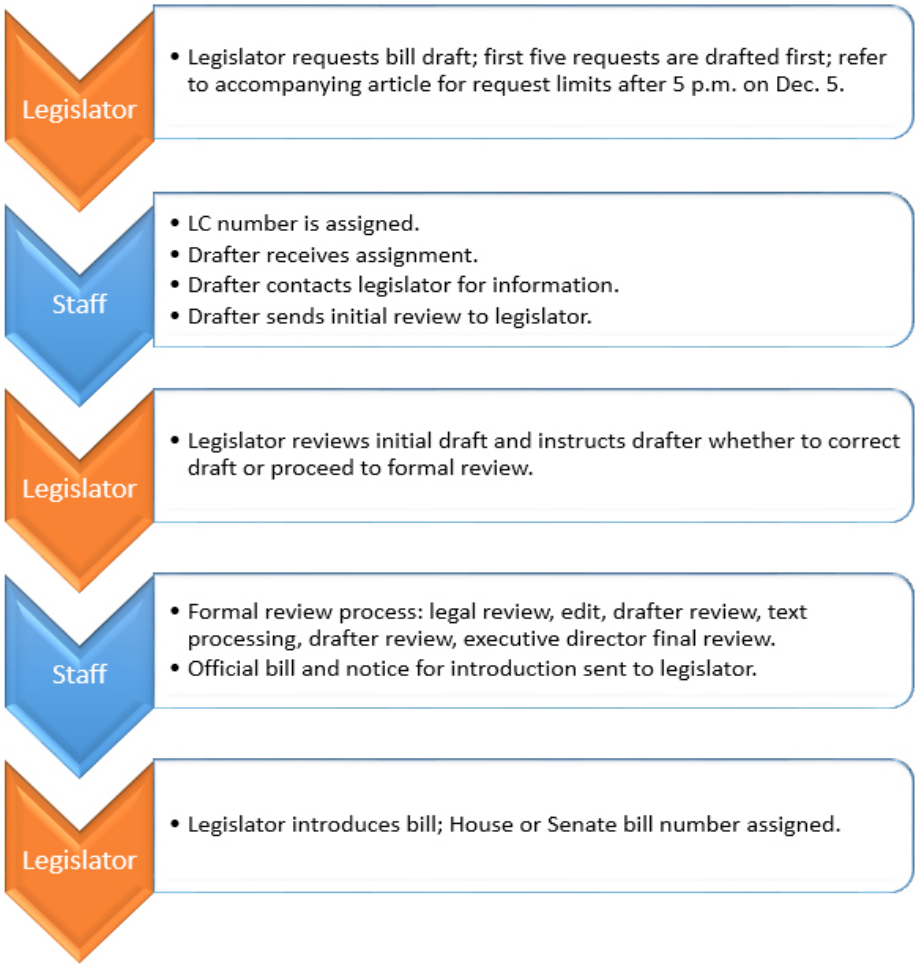
Legislators! Bill Draft Request Process

This article presents information about the bill drafting process for legislators and legislators-elect who want to begin requesting bill drafts for the 2017 legislative session.

- Each legislator's first five bill requests will be drafted first. Thus, you may wish to submit your requests in the chronological order that reflects your top priorities. Even if you put one of your first five requests on hold, drafters will not be able to begin working on your sixth and later bill drafts until they have first worked on other legislators' first five requests. However, be assured that all bills will be drafted.
- Bill draft request forms are available online from our legislative branch home page at www.leg.mt.gov (on the left side of the page, click "Session" and then click "2017 Session") or from the main office of the Legislative Services Division in Room 110 of the Capitol. When filling out this form, please be as specific as possible about what you want the bill to accomplish.
- Bill draft requests may be made to any Legislative Services Division staff member in person, by phone, by e-mail, or by FAX. Our contact information is as follows:

  Montana Legislative Services Division
  Room 110 — State Capitol
  Helena, MT 59620-1706
  406-444-3064
  FAX: 406-444-3036
  E-mail: teverts@mt.gov
- Some limitations apply to the number of bills you may request.
  - Before 5 p.m. on Dec. 5, there are no limits on the number of requests you may submit.
  - After 5 p.m. on Dec. 5, you may request up to seven bills, but after 12 noon on Jan. 2, 2017, when session starts, you are limited to two requests.
  - After Dec. 5, legislators may grant unused bill draft requests to other legislators.
  - These restrictions do not apply to bills proposed by the code commissioner in the Legislative Services Division, bills or resolutions requested by standing committees, or bills or resolutions requested on behalf of newly elected state officials.
- After you submit your request, it will receive an LC number and be assigned to a bill drafter. The bill drafter will contact you to get more information. You will be asked to carefully review an initial draft and provide further instructions.
- After you approve the initial draft, the draft will be forwarded through a formal review process, after which you will receive notice that the official draft is ready for introduction.
- Your bill will receive a Senate bill number or a House bill number at the time you introduce it. The graphic below illustrates this process.
- There are introduction deadlines, which you will be able to reference in the session rules adopted after the session begins.

If you have any questions about this process, please feel free to contact the Legislative Services Division. We stand ready to help you in any way we can.



Legislative Audit Committee Hears Audit Reports

The Legislative Audit Committee met on Oct. 6 to review recently released audit reports. The committee anticipates its next meeting in December. The audits and related findings discussed at the Oct. 6 meeting are summarized below.

Financial and IT Audits

A financial audit of Montana School for the Deaf and Blind (16-22B) makes one recommendation to the school related to internal controls over revenue activity. Unmodified opinions were issued on each of the school's six financial schedules.

A financial compliance audit of the Department of Corrections (16-15) contains seven recommendations to the department related to state youth correctional facility changes, accounting errors, internal control deficiencies, and noncompliance with various state laws applicable to the department.

An information systems audit (16DP-01) of the Status, Tax Accounting, Audit and Rating System (STAARS) at the Department of Labor and Industry provides information about data integrity involved in unemployment insurance contribution system processes. The report also includes recommendations for improvements related to access management, data accuracy, and system changes.

Contracted Audits

The committee reviewed three audits performed by outside accounting firms.

The audit of the Medical Legal Panel, calendar year 2015 (16C-05), identifies no findings.

An audit of the Chiropractic Legal Panel, FY 2015 and FY 2016 (16C-10), found numerous material weaknesses in internal controls over financial reporting related to cash disbursements and cash receipts.

The audit of State Health Care Benefits for calendar years 2014 and 2015 (15C-09) reviewed the claims processing for Cigna, the state's third-party medical administrator, and Delta Dental, the state's third-party dental administrator. The audit scope also included pharmacy claims from MedImpact, which is the Pharmacy Benefit Manager (PBM) for the state. The results indicate that both Cigna and Delta Dental made errors when processing claims. MedImpact also did not meet pricing guarantees.

Other Items

Other agenda items included consideration of the Legislative Audit Division's budget request for the FY 2018-2019 biennium and results of the FY 2017 performance audit prioritization process.

More Information

For more information on the committee's activities, please visit the Legislative Audit Division's website or contact Angus Maciver, legislative auditor.

Division Website: http://leg.mt.gov/audit
Legislative Auditor: amaciver@mt.gov or 406-444-3200

Legislative Council to Consider Rules Subcommittee Report

The Legislative Council's Rules Subcommittee held a conference call on Oct. 25 to consider the proposed rule language for the 2017 legislative session. The subcommittee will report at the next council meeting in November, and the council will forward its recommendations to the Joint, House, and Senate Rules committees that will meet on Dec. 7, 2016.

The council will also receive a budget update, consider bill drafts and assign bill sponsors, receive a TVMT update, and consider a land transfer of the Hamilton Armory from the Department of Military Affairs to the city of Hamilton and forward a recommendation to the Land Board.

Next Meeting

The council will meet at 9 a.m. on Nov. 15 in Room 455 of the Capitol in Helena. For more information on the council's activities and upcoming meeting, please visit the council's website or contact Susan Byorth Fox, council staff.

Council Website: http://leg.mt.gov/legcouncil
Council Staff: sfox@mt.gov or 406-444-3066

RTIC to Adopt Revenue Estimate

The Revenue and Transportation Interim Committee will hold its final meeting of the interim on Nov. 17 with the main objective of adopting a revenue estimate for introduction to the 2017 legislative session. State law requires the committee to introduce by Dec. 1 preceding each regular legislative session an estimate of the amount of revenue projected to be available for legislative appropriation.

The Legislative Fiscal Division and the Office of Budget and Program Planning will each present their significant assumptions for the committee's consideration. The committee is then expected to adopt a preliminary ending fund balance, a general fund revenue estimate, and an estimate for selected nongeneral fund revenue sources.

Other Agenda Items

The committee will start the day with two agenda items not related to the revenues estimate: an administrative rule review and a required report from the Department of Revenue.

In addition to reviewing recently proposed and adopted administrative rules, staff attorney Jaret Coles will provide a requested update on the Department of Transportation's timeline for reviewing an administrative rule, ARM 18.7.202. The committee requested review of this rule after receiving public comment about the rule from the Gallatin Gateway Water and Sewer District at the committee's September meeting.

The Department of Revenue will provide a required report on the tax rates for the upcoming property reappraisal cycle that will result in taxable value neutrality for each property class. Senate Bill 157 (2015)—which revised reappraisal laws to provide for a two-year reappraisal cycle for residential, commercial, and agricultural property—also required this report to the committee.

Final Meeting

The committee will meet at 8 a.m. on Nov. 17 in Room 317 of the Capitol in Helena. For more information on the committee's activities and upcoming meeting, please visit the committee's website or contact Megan Moore, committee staff.

Committee Website: www.leg.mt.gov/rtic
Committee Staff: memoore@mt.gov or 406-444-4496

State Administration Committee to Review Pension Plan Actuarial Valuations

The State Administration and Veterans' Affairs Interim Committee will meet on Nov. 17 to review the recently completed actuarial valuations of Montana public employee pension plans. As summarized in the October issue of *The Interim*, the committee will also finalize its recommendations on the personal information ownership study under House Joint Resolution 21 (2015) and veteran suicide prevention.

Figure 1: Funding Status Summary

System	Funded Ratio	ARC Shortfall (% payroll)	Amortization period (years)
PERS-DB	77%	0%	26
TRS	69%	0%	24
SRS	83%	3.39%	does not amortize
MPORS	69%	0%	18
GWPORS	84%	2.08%	does not amortize
FURS	78%	0%	9
HPORS	66%	0%	28
JRS	166%	0%	0

Source: Fiscal year 2016 actuarial valuations.

Pension Plan Funding Status

Figure 1 is a table summarizing the basic actuarial funding status of each of Montana's defined benefit retirement plans (or systems) for state and local public employees.

Following is a description of the acronyms and terms used in the table:

PERS-DB – Public Employees' Retirement System–Defined Benefit Plan

TRS – Teachers' Retirement System

SRS – Sheriffs' Retirement System

MPORS – Municipal Police Officers' Retirement System

GWPORS – Game Wardens' and Peace Officers' Retirement System

FURS – Firefighters' Unified Retirement System

HPORS – Highway Patrol Officers' Retirement System

JRS – Judges' Retirement System

"Funded Ratio" means current assets compared to current liabilities. When a plan is 100 percent funded, it means current assets are sufficient to pay 100 percent of current liabilities.

"ARC Shortfall" means the shortfall in the contributions (as a percent of payroll) that are needed to amortize the system's unfunded liabilities in 30 years. If there is a shortfall, then the plan's unfunded liabilities cannot be paid off (amortized) in a period of 30 years or less and actuaries consider the system to be actuarially unsound.

"Amortization Period" means the number of years it will take to pay off the system's unfunded liabilities with current

contribution rates. If contribution rates are insufficient to pay off the unfunded liabilities in any amount of time, then the liabilities "do not amortize" and the system is considered actuarially unsound.

Final Meeting

The committee will hold its final meeting of the interim on Nov. 17 in Room 102 of the Capitol in Helena at a time to be determined. For more information on the committee's activities and upcoming meeting, please visit the committee's website or contact Sheri Scurr, committee staff.

Committee Website: http://leg.mt.gov/sava
Committee Staff: sscurr@mt.gov or 406-444-3596

Water Committee Proposes Assumption of Federal Permitting Program

The Water Policy Interim Committee wrapped up its 2015-2016 interim by forwarding four more bills to the 2017 Legislature. At its Oct. 12 meeting, the committee approved bill drafts to do the following:

- **Limit adverse effects analysis.** This bill would allow a senior water rights holder to file a "consent to approval," which would allow an applicant for a new water right or a change in appropriation right to ignore the adverse effect on that senior water right, in order to receive that permit or change authorization.
- **Establish a surface water assessment and monitoring program.** This legislation would establish a program within the Montana Bureau of Mines and Geology for surface water assessment and monitoring and would provide a $250,000 annual statutory appropriation. The bill would also establish program duties and a steering committee.
- **Allow water court review of certain Department of Natural Resources and Conservation decisions.** This bill would allow an applicant to appeal a DNRC decision on a water rights permit or a change of appropriation right to either the district court or the Water Court.
- **Direct the Department of Environmental Quality to assume dredge-and-fill permitting.** This legislation would direct the DEQ to assume the dredge-and-fill permitting program if and when the U.S. Army Corps of Engineers and the Environmental Protection Agency fully enforce the final rule defining "waters of the United States," as published in the Federal Register on June 29, 2015.

Exempt Wells

The committee also discussed the Montana Supreme Court's September ruling on exempt wells. The court upheld Judge Jeffrey Sherlock's 2014 decision that the DNRC's 1993 administrative rule defining a "combined appropriation" as physically connected exempt wells was improper. The Supreme Court's ruling means the cumulative flow rate of all wells in a development must be less than 35 gallons per minute with a total volume of less than 10 acre-feet a year in order to qualify for the ground water exemption. Otherwise, a developer needing more water would likely require a permit for a larger appropriation. At the October meeting, the committee considered a draft piece of legislation to address the issue but took no formal action.

Previously Approved Bills

At its August meeting, the committee approved the following drafts for the 2017 Legislature's consideration:

- LC 323 – Clarify water commissioner petition process.
- LC 324 – Require an education program for water commissioners.
- LC 325 – Clarify the definition of "water right change."
- LC 326 – Provide a statutory appropriation for the Ground Water Investigation Program.
- LC 327 – Revise water right disclosure laws.

In addition, WPIC approved four bill requests from DNRC, also for 2017:

- LC 480 – Revise temporary water lease laws.
- LC 481 – Revise the definitions of "salvage water" and "water conservation."
- LC 482 – Revise the process for claims for existing rights for livestock and individual uses.
- LC 483 – Revise water right abandonment laws to account for drought plans.

More Information

The committee will not meet again this interim. For more information on the committee's activities, please visit the committee's website or contact Jason Mohr, committee staff.

Committee Website: www.leg.mt.gov/water
Committee Staff: jasonmohr@mt.gov or 406-444-1640

The Back Page

Medicaid Expansion: How the Assumptions Have Compared to the Experiences

By Sue O'Connell, Legislative Research Analyst

The Montana Legislature wrestled for two sessions with the question of whether to expand Montana's Medicaid program to cover more low-income adults as allowed under the federal Affordable Care Act. When lawmakers finally approved Senate Bill 405 in 2015, supporters hailed the bill as a Montana-made solution that took a new and unique approach to expansion.

That approach included having a private company run the expansion program, requiring enrollees to pay part of the costs, and offering workforce assistance so people could obtain jobs that would lift them out of poverty.

Some opponents, however, questioned whether the projections for the number of enrollees and the potential costs to the state were too low. They pointed to fiscal notes with varying estimates that had been prepared for other expansion proposals in the past.

Nine months into the expansion effort, the state is well ahead of the SB 405 fiscal note projections for enrollees. It also has experienced both unexpected costs and unexpected savings, in part because of decisions made by the federal government after the Legislature went home.

How all the pieces of SB 405 will play out over time remains to be seen. This article looks at the history of the expansion and how the expansion experience to date compares to the predictions made as SB 405 was being debated in the Legislature.

Medicaid: An Overview and Recent History

The U.S. Congress created the Medicaid program in 1965 to pay health care bills for certain low-income individuals who meet other eligibility criteria. Until passage of the Affordable Care Act (ACA), the program primarily covered children and aged, blind, disabled, or pregnant adults. Within those broad categories, states could create their own guidelines for serving people with incomes higher than the level set by federal law or for groups of people other than those required by federal law. In Montana, coverage for most adults outside of the major categories was limited to people with dependent children who had incomes below about 50 percent of the federal poverty level.

ACA opened the door for increased federal funding for covering individuals 19 to 64 years of age who are not pregnant and not disabled and whether or not they have dependent children. It also set the income limit for those individuals at up to 138 percent of the federal poverty level — or $16,242 for a single person this year. ACA also removed eligibility requirements related to assets and income disregards and deductions, basing eligibility solely on the person's modified adjusted gross income.

Both the federal and state governments pay for Medicaid costs. A state's share is based on the state's average per capita income as compared to the national average. In recent years, Montana generally has paid about one-third of the costs, while the federal government has picked up the remainder.

ACA required the federal government to pick up a bigger share of the health care costs for the so-called "expansion population" than it does for those in the traditional Medicaid program. The Medicaid expansion provisions went into effect in 2014, and ACA set the federal share for medical costs at 100 percent for the first three years of the expansion. States must pay 5 percent of the costs in calendar year 2017 and will pay 10 percent by calendar year 2020 and subsequent years.

As passed by Congress, ACA required states to expand Medicaid to the new coverage group if they wanted to continue their Medicaid programs. However, the U.S. Supreme Court overturned that requirement in June 2012, saying it amounted to unconstitutional coercion by threatening loss of all federal funding if states didn't choose to participate in a much-changed program. The court removed the penalty for nonparticipation, essentially making expansion optional for states.

The 2013 Legislature rejected efforts to expand the program. But after lengthy debate, the 2015 Legislature passed SB 405. Supporters said that the additional requirements it contained would encourage people to make better health care choices because they would be paying part of the costs and that the workforce elements could help people improve their economic situations.

Montana is now one of 31 states that have chosen to expand their Medicaid programs.

What SB 405 Required and What CMS Allowed

Known as the Health and Economic Livelihood Partnership (HELP) Act, SB 405 contained several provisions not allowed without a waiver of federal Medicaid law. Those included the requirements that enrollees pay premiums, cover a portion of medical costs, and use health care providers who are in a

network established by a third-party administrator (TPA). As a result, the state had to ask the federal Centers for Medicare and Medicaid Services (CMS) to waive certain federal laws provisions before it could put SB 405 into effect.

CMS, however, didn't give a fully green light to all of Montana's changes. Instead, it imposed some limitations on how broadly the premium and TPA provisions would apply. CMS also required the state to pick up a share of the costs for a feature that the state included in the waiver request, even though it wasn't specifically contained in SB 405. The state asked for what is known as "continuous eligibility" for the expansion group. Under continuous eligibility, a Medicaid enrollee can remain in the program for a full year even if the enrollee's income goes above the amount allowed by law during that time.

Federal law allows for continuous eligibility, and the state, in its waiver application, sought approval for using it as a way to promote "continuity of coverage and access to care" and to minimize what is known as "churn," or people moving in and out of the program as their income changes. However, under SB 405, people with incomes above 100 percent of poverty may still be disenrolled from the program if they fail to pay their premiums.

In return for allowing continuous eligibility, CMS decided it would not pay the full 100 percent matching rate required under ACA for 2.6 percent of the medical claims of the expansion group. Instead, the federal government is paying those claims at the regular matching rate of about 65 percent, leaving the state to cover 35 percent of the costs.

Following is a summary of what SB 405 required the state to do and what steps CMS allowed Montana to take:

- **Premiums:** With a few exceptions, SB 405 required expansion enrollees to pay an annual premium equal to 2 percent of their income. CMS excluded people at or below 50 percent of poverty from paying premiums.
- **Disenrollment:** SB 405 requires enrollees with incomes above 100 percent of poverty to be removed from the program if they fail to pay premiums within 90 days. CMS said enrollees could be reinstated after they have been notified that their premiums are overdue.
- **TPA:** With a few exceptions, SB 405 required expansion enrollees to use providers who are in a network created by the TPA. CMS excluded enrollees at or below 50 percent of poverty from the TPA arrangement, along with others specifically exempted by SB 405 because of their health care needs or inability to access health care providers.
- **Continuous Eligibility:** SB 405 did not explicitly provide for continuous eligibility, but the state asked for permission to use that provision of federal law. CMS allowed it but decided that it would not pay the standard, lower federal matching rate — rather than the enhanced ACA rate — for a small portion of the claims for the expansion population, as noted earlier.

Enrollment Outpaces Estimates

Much discussion during hearings on SB 405 revolved around the number of people likely to sign up for the expanded Medicaid program. The number of enrollees affects the total costs in two ways:

- If more people are in the program, there will be more medical claims to pay.
- The third-party administrator required under SB 405 is paid a monthly administrative fee for each person enrolled in the program. Unlike the medical claims that will receive a high federal matching rate, the federal government pays a lower portion of administrative costs, leaving the state to pick up more of those costs.

Numerous estimates prepared before and during the 2015 session predicted that 70,000 to 80,000 Montanans would meet the income standards for the expansion. However, it was also widely assumed that not all 70,000 of those individuals would sign up right off the bat.

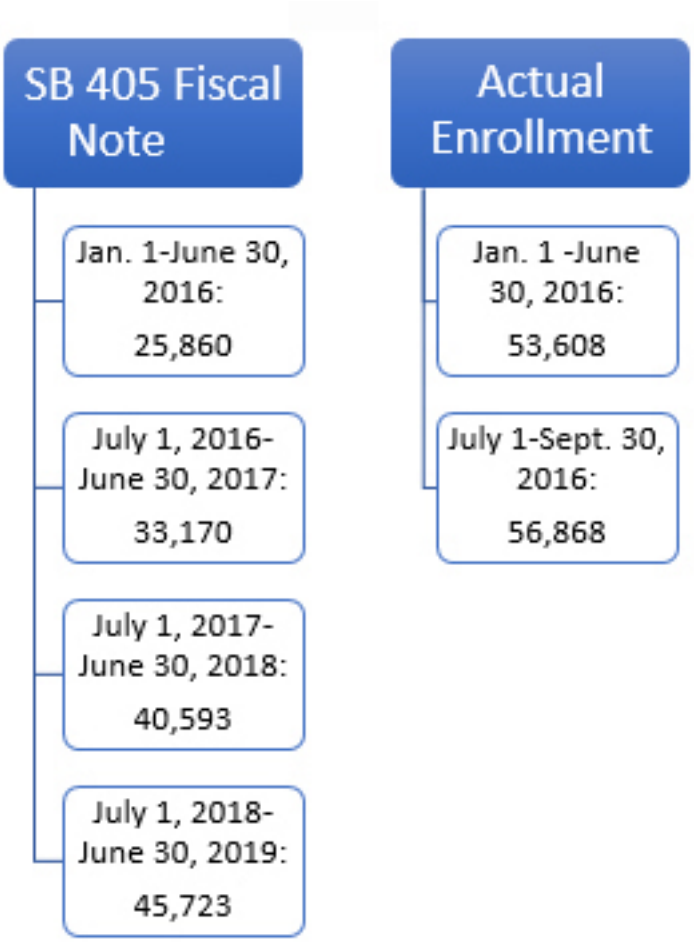
During hearings on the bill, administration officials testified that they expected the premium requirements to inhibit enrollment to some degree. They also said other factors affected their estimates, including calculations on how long it would take people to find out about the availability of coverage and to sign up for it once they found out it was available. The fiscal note assumed that about one-third of the eligible individuals would sign up in the first six months of the program and that enrollment would reach about 46,000 by June 30, 2019.

The Governor's Office of Budget and Program Planning prepares fiscal notes for bills that may affect the state budget. The fiscal notes attempt to predict — before a policy change actually goes into effect — how the change will impact the budget.

Enrollment quickly exceeded the fiscal note projections and was higher nine months into the expansion than the state assumed it would be after four years. The graphic on the following page shows the fiscal note projections and the enrollment experienced so far in each quarter of 2016.

The enrollment number for Sept. 30 is preliminary and will not be considered final until it has been reviewed at the end of November.

DPHHS reports that 2,047 people had been disenrolled through Sept. 30 for failure to pay premiums. Of those, 93 have since paid their premiums and have been reenrolled, while 409 have paid their premiums and are eligible for reenrollment.



Calculating Costs and Savings: An Early Look

The SB 405 fiscal note estimated that the expansion would save about $11.5 million during the current two-year budget period. That estimate was based on, among other things, the assumption that the federal government would be paying all of the medical costs for the expansion population in fiscal year 2016 and 97.5 percent of the costs in the current fiscal year. With continuous eligibility, the state is actually receiving a slightly lower federal matching rate.

In addition, the actual per-person, per-month fee paid to the TPA for administrative costs was higher than projected in the fiscal note, and fewer people are paying premiums because CMS excluded people at 50 percent or less of poverty from that requirement. However, because the state is paying the TPA fee for fewer people than expected, both the TPA contract and the projected overall administrative costs have been lower. DPHHS says it avoided $678,000 in administrative costs in FY 2016 because of the lower overall cost. The TPA contract was expected to cost about $5.5 million in FY 2016 and $7.2 million this fiscal year. But DPHHS indicated that it paid Blue Cross Blue Shield $2.1 million in FY 2016 for TPA services and has paid about $826,000 so far this fiscal year.

The table below shows how some of the fiscal note assumptions have played out in the first nine months of the expansion.

Element	Fiscal Note Estimate	Actual Experience
2016 Federal Funding Level	100 percent	99.1 percent
2017 Federal Funding Level	97.5 percent	96.6 percent
FY 2016 Enrollment	25,860	53,608
FY 2017 Enrollment	33,170	56,868 (first quarter only)
FY 2016 Premium Income	$5.8 million	$1.3 million[1]
FY 2016 TPA Cost	$20.07 per person per month	$26.39 per person per month
FY 2016 Total Administrative Cost	$28.17 per person per month	$25.76 per person per month

The Fiscal Year 2016 HELP Act Savings report, presented by Budget Director Dan Villa to the Legislative Finance Committee in September, said the expansion had saved the general fund $9.3 million during that fiscal year, in part because of savings in other parts of the budget. Overall, the fiscal note estimated that the state would save general fund dollars in the current two-year budget period and begin incurring general fund costs in the next biennium. Those costs were expected to total $27.1 million in FY 2018 and FY 2019.

[1] The fiscal note estimate assumed 12 months of premium payments, even though the expansion would be in effect for only the last six months of the fiscal year. The actual premium income figure reflects six months of payments.

Workforce Assistance Efforts

SB 405 required the state Department of Labor and Industry to create a workforce development program to help Medicaid enrollees improve their employability. Known as HELP-Link, the program offers employment assessments designed to identify other services that will help enrollees improve their job-seeking and labor market skills.

DPHHS notifies all new enrollees about the HELP-Link program when it mails a letter letting them know they've been approved for the Medicaid program. People can take the initial employment assessment online. After that, a Labor Department employee helps identify additional training that may improve employment options.

A person is considered an "active participant" in the program if the person obtains one of several different activities within 90 days of the assessment. Those activities include reviewing workforce supply and demand data, assistance with job matching, and assistance with writing resumes and cover letters and preparing for job interviews.

Active participation in HELP-Link is one of the factors that, in conjunction with at least one other factor, can prevent people from being disenrolled from Medicaid if they fail to pay their monthly premiums.

The most recent figures available from the Department of Labor showed that through Sept. 30:

- 5,896 of the 56,868 people in the Medicaid program at that time had completed the initial workforce survey; and
- 1,004 of them were active HELP-Link participants.

What a Fiscal Note Can't Show

Although fiscal notes and analyses look solely at costs and savings to the state budget, there are also other facets to the Medicaid expansion numbers.

For example, the higher-than-projected enrollment means that more Montanans have coverage for their medical needs. In mid-July, State Auditor Monica Lindeen reported that the number of uninsured Montanans had dropped to an all-time low, thanks in large measure to Medicaid expansion.

In 2013, about 20 percent of Montanans were uninsured, her report noted. The ACA requirement to buy health insurance went into effect in 2014, as did federal subsidies to help people with incomes of 100 percent to 400 percent of poverty buy insurance and to help some of them pay the cost-sharing requirements of their policies. The percentage of uninsured people declined as a result of those requirements, to 16.9 percent in 2014 and to 15 percent in 2015, Lindeen said.

ACA envisioned that all people with incomes at or below 138 percent of poverty would qualify for Medicaid. When the Supreme Court made expansion optional, many of those people fell into a gap. Their incomes were too high for the state's regular Medicaid program and too low to qualify for subsidies to buy private insurance.

With the advent of Medicaid expansion this year, tens of thousands of Montanans gained coverage for their health care costs. Lindeen said the uninsured rate dropped to 7.6 percent by midyear.

Many of the new enrollees have also been receiving preventive health care services, which may improve their overall health and reduce their need for more costly services in the future. And many people testified during hearings on SB 405 that if the Medicaid program were expanded, they would finally be able to obtain medical care for both chronic conditions and serious medical conditions that had gone untreated because they could not afford the care they needed.

In addition, hospitals and other health care providers are now being paid for previously uncompensated care that they provided to uninsured people. The full effect of Medicaid expansion on medical payments won't be known for months, because Medicaid providers have 12 months to bill for the services they provide. However, the HELP Oversight Committee's July report said Medicaid reimbursements to Montana hospitals as of June 30 were well ahead of the amount paid during the same time in 2015.

During the expansion debates in the Legislature, proponents pointed to uncompensated care as a major factor in the rise in health care costs paid by others.

The Road Ahead

SB 405 is slated to terminate on June 30, 2019, unless the Legislature reauthorizes it. With that deadline approaching, the impacts of Medicaid expansion are sure to receive plenty of scrutiny in the next few years from legislators, state agency officials, and CMS, which will have to reauthorize the waivers the state received if the Legislature approves continuation of the program.

CMS will be looking at whether the theories behind the exceptions it granted for Montana's program are holding up. Those theories included the following:

- Premiums and copayments will not be a barrier to enrollment.
- The disenrollment penalty for failure to pay premiums will encourage payment and result in continuity of care.

- The use of a TPA and a defined network of providers will provide equal or greater access to providers than would otherwise be available. In fact, CMS will review the use of the TPA well before SB 405 terminates. The federal agency granted only a two-year waiver for this provision, which will expire at the end of 2017 unless CMS approves a request to continue it.

Legislators, for their part, are likely to closely examine all facets of the expansion, from the number of people enrolled to the payments they're making for coverage and their participation levels in workforce programs. Legislators will also be looking at the costs to the state. The Legislative Fiscal Division's 2019 Biennium General Fund Outlook, published on June 9, 2016, projected those costs to be $69.7 million in the next biennium. That projection did not include any premium income or any of the savings that various SB 405 provisions are expected to create for the state.

Those factors and more are sure to be considered as policymakers weigh the tangible and intangible benefits of expansion against the costs — to the Medicaid program and the overall state budget — of continuing the program.

Next Meeting Dates

- Legislative Council — Nov. 15
- Revenue and Transportation Interim Committee — Nov. 17
- State Administration and Veterans' Affairs Interim Committee — Nov. 17

These dates are current as of Nov. 1, 2016. For the most up-to-date meeting dates and information, please see the individual committee websites.